Client Identification _____ Date _____

Counselor _____ Staff Title _____
(Signature)

_____
(Please Print)

Follow-up Visit Recommended: ☐ Yes ☐ No

Written Referral Given:
- ☐ Mental Health
- ☐ Substance Abuse
- ☐ Prenatal Care
- ☐ Abuse and/or rape*
- ☐ Job
- ☐ Other

**By law, you must report past or present abuse to a child protective agency.*

Length of Visit: ☐ Brief (10-19 minutes) ☐ Extended (20 minutes +)

General Notes:

California Health and Human Services Agency-Department of Health Services
Office of Family Planning

TEEN SMART
QUESTIONNAIRE

Please take a few minutes to fill out these questions.

Some of these questions may be hard to answer. If there are any you don't want to answer or that don't apply to you, just leave them blank.

By law and for your safety, we must report possible physical and sexual abuse to a child protective agency where staff are trained to help teens who are dealing with abuse in their lives.

Anything else you say or write is kept confidential between the clinic staff and you. We will not talk to anyone else about what you tell us.

Family PACT
Planning • Access • Care • Treatment
OFFICE OF FAMILY PLANNING
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

1. Are you going to school?
   - ☐ Yes
   - ☐ No, I graduated/I have my GED
   - ☐ No, I stopped going to school

2. How old are you?
   _____

3. Which ethnic group describes you? (Optional) *(Check all that apply)*
   - ☐ Latino/Hispanic
   - ☐ White/Caucasian
   - ☐ Black/African American
   - ☐ Asian
   - ☐ Other: _____

Your feelings about sex and pregnancy

4. Have you ever had sex? *(Check all that apply)*
   - ☐ Yes, vaginal sex (penis in vagina)
   - ☐ Yes, oral sex (mouth on penis or vagina)
   - ☐ Yes, anal sex (penis in anus or butt)
   - ☐ No, I've never had sex

5. If yes, have you ever had sex with a: *(Check all that apply)*
   - ☐ Male
   - ☐ Female

6. If yes, how old were you the first time you had sex?
   - ☐ 15 or younger
   - ☐ 16 or older

7. If you've never had sex, are you:
   - ☐ Planning to wait until _____
   - ☐ Thinking about having sex soon
   - ☐ Not sure

8. Have you ever been forced or pressured to have sex when you did not want to?
   - ☐ Yes*
   - ☐ No

9. How old do you want to be when you have your first or next child?
   - ☐ 19 or younger
   - ☐ 20 or older
   - ☐ Don't plan to have any/more children
   - ☐ Not sure

10. Do you want to be pregnant now?
    - ☐ No
    - ☐ Yes
    - ☐ Not sure

11. Do you have a partner who wants you to be pregnant now?
    - ☐ No
    - ☐ Yes
    - ☐ We haven't talked about it

12. How likely is it that you will get pregnant in the next year?
    - ☐ It won't happen
    - ☐ It will happen
    - ☐ It may happen

If you've never had sex, please skip to question #30

13. In the past month, about how often did you have sex?
    - ☐ Not at all
    - ☐ 3 times or less
    - ☐ 4 or more times

14. In the past 6 months (including today)have you ever thought you might be pregnant?
    - ☐ No
    - ☐ Yes (How many times?) _____

15. Have you ever been pregnant?
    - ☐ No
    - ☐ Yes (Number of times?) _____

16. Are you a parent now?
    - ☐ No
    - ☐ Yes

Choosing a birth control method

17. Have you ever used any birth control method (like the pill or condoms) to keep from getting pregnant?
    - ☐ Yes
    - ☐ No

18. If yes, when did you first use something to keep from getting pregnant? *(Check one)*
    - ☐ Before I started having sex
    - ☐ 0-3 months after I started having sex
    - ☐ 4-11 months after I started having sex
    - ☐ A year or more after I started having sex

19. Which methods have you used? *(Check all that apply)*
    - ☐ Nothing
    - ☐ Withdrawal (pulling out)
    - ☐ Condom (for men or women)
    - ☐ Foam, spermicides, film or suppositories
    - ☐ Pill
    - ☐ The "shot" (Depo)
    - ☐ Other: (What?) _____

20. The last time you had sex, what did you use to keep from getting pregnant? *(Check all that apply)*
    - ☐ Nothing
    - ☐ Withdrawal (pulling out)
    - ☐ Condom (for men or women)
    - ☐ Foam, spermicides, film or suppositories
    - ☐ Pill
    - ☐ The "shot" (Depo)
    - ☐ Other (What?)_____

21. Do you want to begin using a birth control method or change to a new one?
    - ☐ No
    - ☐ Yes (Please tell why) _____
      _____

22. Do you have a partner who discourages you from using birth control/condoms?
    - ☐ Yes
    - ☐ No

23. How easy is it for you to talk about sex and birth control with the person/people you have sex with?
    - ☐ Most of the time it's easy
    - ☐ Sometimes it's hard
    - ☐ We don't talk about it

Protecting yourself from STDs (Sexually Transmitted Diseases)

24. During the past 6 months, how many people have you had sex with? *(Check one)*
    - ☐ None
    - ☐ One
    - ☐ 2 or more

25. Do you use drugs or drink alcohol when you have sex?
    - ☐ Some of the time
    - ☐ Most of the time
    - ☐ Never

26. Have you ever had an STD (like herpes, gonorrhea, chlamydia, or genital warts)?
    - ☐ Yes
    - ☐ No
    - ☐ Not sure

27. The last time you had sex, did you or your partner use a condom?
    - ☐ Yes
    - ☐ No
    - ☐ Not sure

28. Do you use condoms or other protection (dental dam or latex barrier) if you have:

    Oral sex? (mouth on penis or vagina)
    - ☐ Yes
    - ☐ No
    - ☐ Never had oral sex

    Anal sex? (penis in anus or butt)
    - ☐ Yes
    - ☐ No
    - ☐ Never had anal sex

29. Do you have a partner who sometimes won't use a condom?
    - ☐ Yes
    - ☐ No

Can We Help?

30. What do you do when you're upset or having problems? *(Check all that apply)*
    - ☐ Talk to someone (Who?) _____
    - ☐ Pray or meditate
    - ☐ Spend time alone
    - ☐ Exercise
    - ☐ Watch TV/listen to music
    - ☐ Eat/sleep
    - ☐ Smoke cigarettes
    - ☐ Get high or drink alcohol
    - ☐ Something else (What?) _____
    - ☐ I don't do anything

31. Would you like help with or information on any of these things? *(Check all that apply)*
    - ☐ Basic needs (food, place to live, work)
    - ☐ Problems in school or at home
    - ☐ Alcohol or other drug use
    - ☐ Cigarette smoking
    - ☐ Feeling sad or depressed
    - ☐ Thoughts of hurting myself
    - ☐ Thoughts of suicide
    - ☐ Controlling my temper (keeping from hitting or yelling at others)
    - ☐ Physical abuse (being hit, slapped, punched or choked by anyone)*
    - ☐ Sexual abuse (being touched where you didn't want to be; being forced to have sex)*
    - ☐ Other _____
    - ☐ I don't want help right now

Thank you for taking the time to fill out this survey.

**For your safety and by law, we must report past or present abuse to a child protective agency that is trained to help those who are dealing with abuse in their lives.*

Counselor: Please review limits of confidentiality and disclosure requirements with the client

1. Are you going to school?
   - ☐ Yes
   - ☐ No, I graduated/I have my GED
   - ☐ No, I stopped going to school

2. How old are you? _____
   - If teen is age 16 or older
   - If teen is age 15 or younger

3. Which ethnic group describes you? (Optional) *(Check all that apply)*
   - ☐ Latino/Hispanic
   - ☐ White/Caucasian
   - ☐ Black/African American
   - ☐ Asian
   - ☐ Other: _____

Your feelings about sex and pregnancy

4. Have you ever had sex? *(Check all that apply)*
   - ☐ Yes, vaginal sex (penis in vagina)
   - ☐ Yes, oral sex (mouth on penis or vagina)
   - ☐ Yes, anal sex (penis in anus or butt)
   - ☐ No, I've never had sex

5. If yes, have you ever had sex with a: *(Check all that apply)*
   - ☐ Male
   - ☐ Female

6. If yes, how old were you the first time you had sex?
   - ☐ 15 or younger
   - ☐ 16 or older

7. If you've never had sex, are you:
   - ☐ Planning to wait until _____
   - ☐ Thinking about having sex soon
   - ☐ Not sure

8. Have you ever been forced or pressured to have sex when you did not want to?
   - ☐ Yes*
   - ☐ No

9. How old do you want to be when you have your first or next child?
   - ☐ 19 or younger
   - ☐ 20 or older
   - ☐ Don't plan to have any/more children
   - ☐ Not sure

10. Do you want to be pregnant now?
    - ☐ No
    - ☐ Yes
    - ☐ Not sure

11. Do you have a partner who wants you to be pregnant now?
    - ☐ No
    - ☐ Yes
    - ☐ We haven't talked about it

12. How likely is it that you will get pregnant in the next year?
    - ☐ It won't happen
    - ☐ It will happen
    - ☐ It may happen

If you've never had sex, please skip to question #30

13. In the past month, about how often did you have sex?
    - ☐ Not at all
    - ☐ 3 times or less
    - ☐ 4 or more times

14. In the past 6 months (including today)have you ever thought you might be pregnant?
    - ☐ No
    - ☐ Yes (How many times?) _____

15. Have you ever been pregnant?
    - ☐ No
    - ☐ Yes (Number of times?) _____

16. Are you a parent now?
    - ☐ No
    - ☐ Yes

Choosing a birth control method

17. Have you ever used any birth control method (like the pill or condoms) to keep from getting pregnant?
    - ☐ Yes
    - ☐ No

18. If yes, when did you first use something to keep from getting pregnant? *(Check one)*
    - ☐ Before I started having sex
    - ☐ 0-3 months after I started having sex
    - ☐ 4-11 months after I started having sex
    - ☐ A year or more after I started having sex

19. Which methods have you used? *(Check all that apply)*
    - ☐ Nothing
    - ☐ Withdrawal (pulling out)
    - ☐ Condom (for men or women)
    - ☐ Foam, spermicides, film or suppositories
    - ☐ Pill
    - ☐ The "shot" (Depo)
    - ☐ Other: (What?) _____

20. The last time you had sex, what did you use to keep from getting pregnant? *(Check all that apply)*
    - ☐ Nothing
    - ☐ Withdrawal (pulling out)
    - ☐ Condom (for men or women)
    - ☐ Foam, spermicides, film or suppositories
    - ☐ Pill
    - ☐ The "shot" (Depo)
    - ☐ Other (What?)_____

21. Do you want to begin using a birth control method or change to a new one?
    - ☐ No
    - ☐ Yes (Please tell why) _____

22. Do you have a partner who discourages you from using birth control/condoms?
    - ☐ Yes
    - ☐ No

23. How easy is it for you to talk about sex and birth control with the person/people you have sex with?
    - ☐ Most of the time it's easy
    - ☐ Sometimes it's hard
    - ☐ We don't talk about it

Protecting yourself from STDs (Sexually Transmitted Diseases)

24. During the past 6 months, how many people have you had sex with? *(Check one)*
    - ☐ None
    - ☐ One
    - ☐ 2 or more

25. Do you use drugs or drink alcohol when you have sex?
    - ☐ Some of the time
    - ☐ Most of the time
    - ☐ Never

26. Have you ever had an STD (like herpes, gonorrhea, chlamydia, or genital warts)?
    - ☐ Yes
    - ☐ No
    - ☐ Not sure

27. The last time you had sex, did you or your partner use a condom?
    - ☐ Yes
    - ☐ No
    - ☐ Not sure

28. Do you use condoms or other protection (dental dam or latex barrier) if you have:

    Oral sex? (mouth on penis or vagina)
    - ☐ Yes
    - ☐ No
    - ☐ Never had oral sex

    Anal sex? (penis in anus or butt)
    - ☐ Yes
    - ☐ No
    - ☐ Never had anal sex

29. Do you have a partner who sometimes won't use a condom?
    - ☐ Yes
    - ☐ No

Can We Help?

30. What do you do when you're upset or having problems? *(Check all that apply)*
    - ☐ Talk to someone (Who?) _____
    - ☐ Pray or meditate
    - ☐ Spend time alone
    - ☐ Exercise
    - ☐ Watch TV/listen to music
    - ☐ Eat/sleep
    - ☐ Smoke cigarettes
    - ☐ Get high or drink alcohol
    - ☐ Something else (What?) _____
    - ☐ I don't do anything

31. Would you like help with or information on any of these things? *(Check all that apply)*
    - ☐ Basic needs (food, place to live, work)
    - ☐ Problems in school or at home
    - ☐ Alcohol or other drug use
    - ☐ Cigarette smoking
    - ☐ Feeling sad or depressed
    - ☐ Thoughts of hurting myself
    - ☐ Thoughts of suicide
    - ☐ Controlling my temper (keeping from hitting or yelling at others)
    - ☐ Physical abuse (being hit, slapped, punched or choked by anyone)*
    - ☐ Sexual abuse (being touched where you didn't want to be; being forced to have sex)*
    - ☐ Other _____
    - ☐ I don't want help right now

OVERALL RISK: __ Low __ Moderate/High

CLIENT PRIORITY ISSUES: *(Check all that apply)*

__ BCM __ Counseling/Information __ Physical Exam
__ Pregnancy Test __ Infection/STI check Other: .....

ISSUES DISCUSSED: __ Pregnancy Risk __ BCM Options
__ Method Use __ STD Risk

PSYCHOSOCIAL ISSUES:

__ Substance Abuse __ Suicidal Thoughts __ Depression
__ Family/Partner Issues __ Physical/Sexual Abuse*
Other: .....

**By law, you must report past or present abuse to a child protective agency.*